Authorization to Use and Disclose Health Information In a Professional Publication

We are asking you to let us use and disclose information and/or photos YES ○ NO ○ photo use about your medical condition **Describe Condition** and treatment for a medical/professional journal case report or article.

You have received treatment at the Sargent Choice Nutrition Center ("Sargent Choice"). **Author / Provider** {and the other providers involved in your care} would like to write a case note/article for publication about your diagnosis, treatment and follow-up to a medical journal: **Name of Journal** . The purpose is to inform and teach other health care providers. The journal is published in print and on the internet.

WHAT IS IN THE CASE REPORT OR ARTICLE?

The case report or article will describe your condition and may describe your health history, complaints, treatment, medications and response to treatment.

We will not use your name in the case report or article. But people who know you may be able to tell who you are. The people who publish the journal will know your name because they require us to give them a copy of this form. They want to be sure that you have given permission. However, they will not tell anyone else your name.

PRIVACY OF YOUR HEALTH INFORMATION

Federal and state law require the Sargent Choice staff and health professionals to keep your health information confidential, except as allowed by law or by authorization. If you sign this Authorization, those who receive the information you are authorizing be disclosed may not be required to protect health information in the same manner.

LETTING US USE AND SHARE YOUR INFORMATION IS VOLUNTARY

Your participation is completely up to you. You do not have to agree to let us use or share your medical information. Your decision (either yes or no) will not affect your being able to get care at Sargent Choice or payment for your health care. It will not affect your enrollment in any health plan or benefits to which you may be entitled. Your permission will last until the authors send the final version of the article to the journal.

REVOCATION

You have the right to revoke this Authorization. To do so please send a written revocation to:

Boston University HIPAA Privacy Officer
Boston University
1 Silber Way, Room 909
Boston, MA 02215
hipaa@bu.edu

If you take back your authorization, it will not affect any actions we took before we received your letter.

SIGNATURE

If you sign this form, you are agreeing to let Sargent Choice and your health care providers use or give out your health information as described above.

Printed Name

Relationship (if not patient)

Signature

Date